NC DIVISION MH/DD/SAS RESIDENTIAL TREATMENT MEDICAID AUDIT 2007/2008

PARENT COMPANY:			**AUDIT DATE:**
PROVIDER NAME:			**NAME:**
PROVIDER #			**SERVICE TYPE:**
CONTROL #:	**DOB/AGE:**		**SERVICE DATE:**
CS PROVIDER 1:			**CS PROVIDER 1 #**
RECORD #:	***Rank:***		**MEDICAID #:**
CS PROVIDER 2:			**CS 2 OTHER INFO:**

RATING CODES: O = Not Met/No 1 = Met/Yes 2 =Not Met/No Payback 6 = No service note 7 = Provider name not available 8 = Repaid before audit list sent 9 = NA		**RATING**
1. Was an authorization in place covering this date of service? **a. If NOT MET list dates FROM:_____ TO:_____**		
2. Is there a valid service order/CON for the service billed?		
3. Is the PCP current with the date of service?		
4. Is the documentation signed by the person who delivered the service within the designated time frame?		
5. Does the service note(s)/log reflect purpose of contact, staff intervention, assessment of progress toward goals?		
6. Does the service note(s) relate to goals listed in the PCP?		
7. Does the documentation indicate that the requirements of the service definition/rule were met? *[see instructions]* **a. If NOT MET, list program / work days here: FROM_____TO_____; AND** **b. List DATES here: FROM_____ TO_____**		
8. Was face-to-face clinical consultation by a Licensed Professional provided at least 4 hrs/wk? ***[Level III only. N/A Level II Program, Level IV and PRTF]***		
9. a. Are the service notes/logs individualized per person?	**a.**	
b. Is the PCP individualized per person?	**b.**	
10. Does the documentation reflect treatment for the duration of service?		
QUALIFICATIONS / SUPERVISION / RECORD CHECKS: (List names of staff not in compliance below)		
11. Is there documentation that the staff is qualified (demonstrates knowledge, skills and abilities per State rules and provider policy) for the service provided? **a. If NOT MET list dates FROM:_____ TO:_____**		
12. a. Is an individualized supervision plan in place for paraprofessional and/or AP staff ?	**a.**	
b. Is the plan implemented?	**b.**	
c. If "a or b" is NOT MET list dates FROM:_____ TO:_____		
13. a. Did the provider agency require disclosure of any criminal conviction by the staff person(s) who provided this service, prior to employment? *[hired prior to 3/24/05]*	**a.**	
b. Was the appropriate Criminal Record check requested prior to this date of service? *[hired on or after 3/24/05]*	**b.**	
c. If "a or b" is NOT MET list dates FROM:_____ TO:_____		
14. Did the provider agency complete a Health Care Personnel Registry check prior to this date of service? **a. If NOT MET list dates FROM:_____ TO:_____**		

COMMENTS:

AUDITOR:	**LME:**